

Adapt of Missouri
ITCD

Arthur Center
ITCD

Bootheel Counseling Services
ITCD, DBT

Burrell Behavioral Health
ACT, ACT-TAY, SPECIALTY
TEAMS, ITCD, DBT

BJC Behavioral Health
ACT TAY, ITCD, DBT

Clark Mental Health Center
ITCD

Compass Health
ACT, ACT-TAY, SPECIALTY
TEAMS, ITCD, DBT

Community Counseling Center
DBT, ITCD

Comprehensive Mental Health
Services
ACT-TAY, ITCD

Comtrea
ITCD, DBT

Family Counseling Center
ITCD

Family Guidance Center
ITCD

Hopewell
ACT TAY, ITCD

Independence Center
ITCD

Mark Twain Behavioral Health
ITCD, DBT

Mineral Area
ITCD

New Horizons
ITCD

North Central MHC
ITCD

Ozark Center
ACT, ACT-TAY, ITCD, DBT

Ozarks Healthcare
ITCD

Places for People
ACT, FACT, ITCD, DBT

Preferred Family Healthcare
ACT TAY, ITCD

ReDiscover
ITCD, DBT

St. Patrick Center
ACT

Swope Health Services
ITCD

Tri-County Mental Health
ITCD, DBT

University Health
ITCD, DBT

EVIDENCE BASED SERVICES NEWSLETTER

- **ASSERTIVE COMMUNITY TREATMENT (ACT) WEB PAGE—[CLICK HERE](#)**
- **INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS (ITCD) WEB PAGE—[CLICK HERE](#)**
- **DIALECTICAL BEHAVIOR THERAPY (DBT) WEB PAGE—[CLICK HERE](#)**

FALL 2023

PAGE 1

Hello from DMH

By Ronda Oswald Reitz, DBT Coordinator

There was a hush over the dark auditorium, all attention focused on the stage where Marsha Linehan and Cindy Sanderson made the impossible seem...possible, and maybe even likely. Where recovery from Borderline Personality Disorder was becoming the reliable outcome of a new treatment called Dialectical Behavior Therapy (DBT). It was the Spring of 1996 and the manual for this treatment was three years old. Research on the benefits of DBT was exploding. Marsha was presenting all over the world, including at some unlikely places for behavior therapy to be promoted, like this day at the Menninger Foundation in Topeka, Kansas, an important home to psychoanalysis. A small group of us from a local mental health center were in attendance, excited to learn directly from the treatment developer. We had already begun a consultation team and our enthusiasm, spurred on by this 2-day introductory training, led us to develop a large DBT program that continues to function today.

Good fortune seems to have placed innovative thinkers along key points of my career path. These administrators and supervisors had things in common with each other. They believed it was both important and possible to provide excellence in care to public mental health consumers. They believed that empirically based treatments were worth sacrificing training dollars and direct service

hours for. And they imbued their clinicians with the trust and autonomy that create a work environment where the highest standards can flourish. I will forever be grateful to these people, some of whom I work among today at the Department of Mental Health in Missouri. In 2002 I left a thriving program in Kansas to develop a DBT program at Fulton State Hospital and then in the other state hospitals. That same year I became a trainer for BehavioralTech, the company Marsha Linehan founded to disseminate her treatment. In that capacity I participated in annual training by Marsha Linehan and others, I've trained and consulted with providers from all over the world, and have been privy to the leading edge of standard development in DBT (which I bring home to apply in Missouri).

In 2007 I took on the job I hold now, as the DBT Coordinator for DMH. The vision for this position was to develop DBT in the communities where our state hospital patients would go to live beyond their admissions. Where community members could access treatment, ultimately preventing hospital admissions. The model I developed for disseminating the treatment was designed to foster high fidelity programs and an informed therapist and consumer population. By cycling through a series of three trainings, large groups of clinicians could be trained, formed into consultation teams, and supported in a

nation-wide model that included both public and private mental health providers in inpatient and outpatient settings, and for adolescents and adults. My work has been primarily to train, develop and support teams and individual clinicians, to consult on difficult cases, and to provide care to a small caseload of my own. This was all held together and supported by a website that does the work of 10 people in handling training registrations, a registry of consultation teams, and provides a model for teams to follow to build increasing fidelity in their programs (dbtmo.org). In the last several years, the DMH Fidelity Team, led by Lori Long began to review public mental health programs according to national standards.

Unbelievably, Marsha Linehan's treatment manual is 30 years old now! It still remains the best guide we have for treatment of complex, multi-diagnostic clients. The treatment has been supported for use with populations well beyond those who meet criteria for Borderline Personality Disorder. While it is lauded as the best treatment available for suicide and self-harm behaviors, DBT's central purpose is not simply to keep people alive, but rather to help individuals who are in emotional hell find a life that is worth living. A life they want to protect. The treatment begins with a team of dedicated clinicians who meet weekly for two hours to continue to build their own expertise and to support each other. Clients are considered under the care of the entire team. Each week, clients receive an hour of individual therapy, two hours of skills training (think: classroom), and 24/7 coaching by the individual therapist. Standard care is for one year. Clients are taught to become more attuned to their internal and external lives, to tolerate the experience of painful emotion without reacting, and to skillfully move toward experiences in life that they deeply value. Being trained as a therapist in the model can feel a bit overwhelming. In fact, some people compare it to sipping water from a

fire hydrant. However, with training and the support of a team, most clinicians master this treatment within the first year of delivery.

The "State of Missouri Certification" process, developed only as a stop-gap measure pending the eventuality of National Certification, has now become "State of Missouri Verification". The vision of moving to a standard of National Certification is happening, although slowly. Missouri has 18 Nationally Certified DBT Clinicians and more who are waiting in the wings to take their exams. Nationally Certified or Missouri registered DBT team members can bill a small amount more for DBT services via MOHealthNet. It is my fervent hope that DBT offered at a high standard of fidelity will someday be protected in Missouri beyond DMH with a formal set of standards and a much higher rate of reimbursement for services as is now being done elsewhere. In the meantime, we will continue to provide high quality training and support to foster the highest standard of DBT programming.

If you would like to attend training, we would love to see you! Whether or not you ever choose to deliver DBT treatment, it's helpful to attend the training "DBT: Making it work in our communities", to improve your understanding of how to make appropriate referrals and what is required of both therapist and client in this treatment. We also have family members and clients attend these trainings. Some of the trainings are low cost, and most remain free of cost. To register, go to www.dbtmo.org and look under "Training Events".

If you'd like to know more about DBT prior to committing to a full training, watch this fun video about DBT for Adolescents:

<https://www.youtube.com/watch?v=Stz--d17ID4>



To find past issues of the Newsletters go to the DMH web pages at:

<https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/provider-act>

Or

<https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/itcd>

Scroll down to “newsletters” and find your archived online copy!

INSIDE THIS ISSUE:

ITCD Map, Team Data Results 3

Team Spotlight; Trainings 4

Fidelity Corner 5

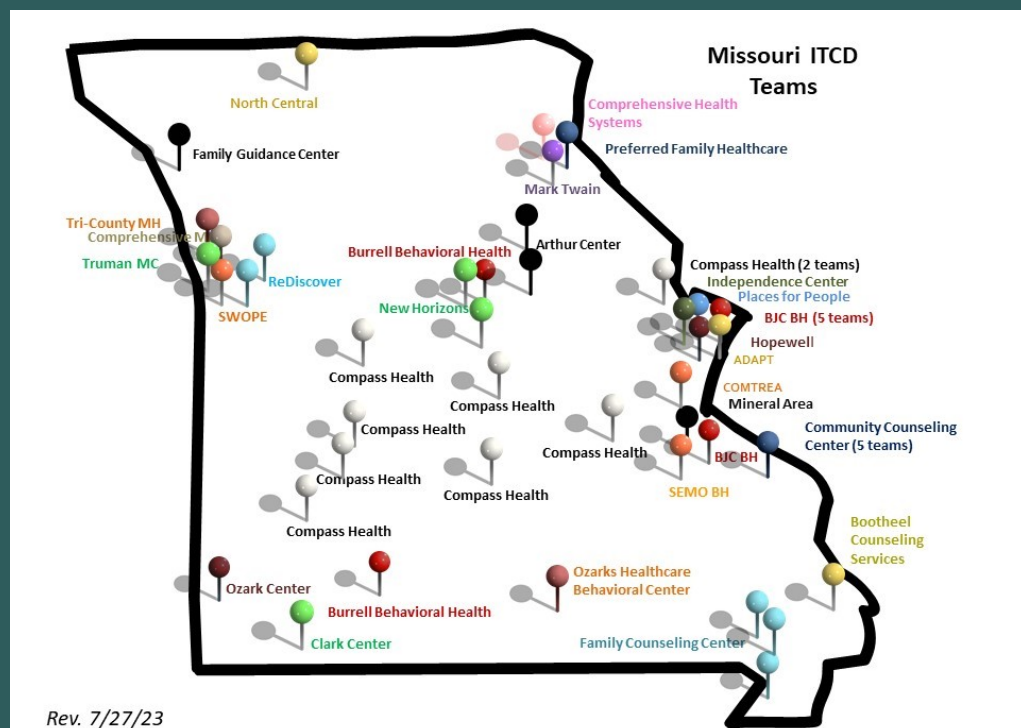
Resources, ACT Map 6

Save the Date; Fidelity team 7

DBT Map; EBP Data Boards 8

Motivational Corner 9

The Arts 10



Congratulations Burrell Springfield ACT-TAY!

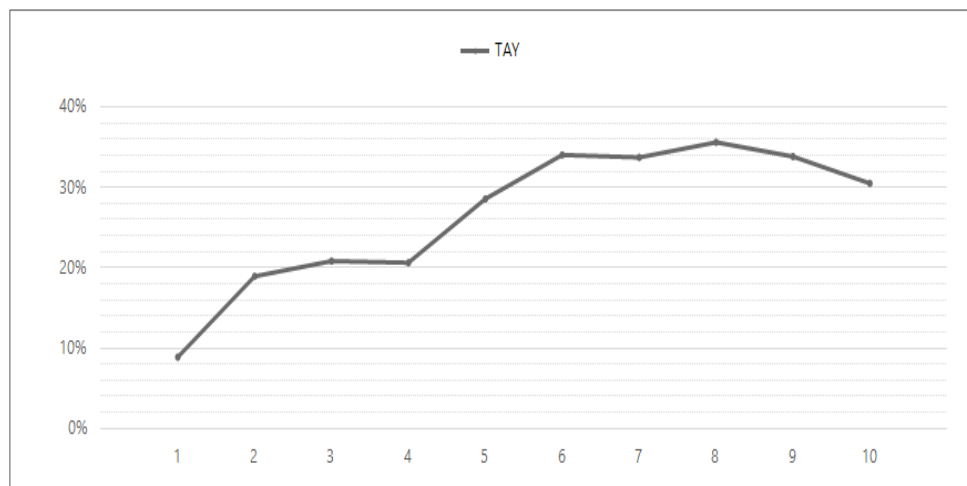
Quarterly data received on each client by the team is showing that over the course of the client's 10 treatment quarters, there is a clear trend of them utilizing primary medical care.

This is in line with what other teams reflected in the statewide data trend for this outcome.

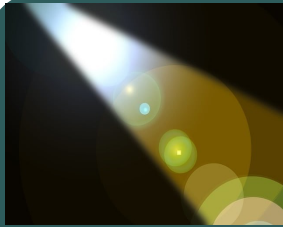
[Start Page](#)

Percent Using Primary Care Provider for Burrell Springfield TAY From Quarters 1 To 10

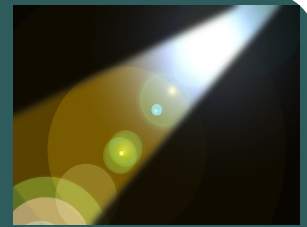
[Back](#)



TEAM SPOTLIGHT



By Robert Doss, PhD, PLP
Mitra Pedram, LCSW
Stacy Parmer, LPC, LMFT
Comprehensive DBT Program
Burrell Behavioral Health



One of my favorite things about working with individuals who struggle with emotion regulation is helping them realize that they are not to blame for how they are. Individuals with borderline personality disorder (BPD), and other disorders characterized by emotion dysregulation, often interact with friends, family members, co-workers, health care providers, therapists, psychiatrists, and strangers who all believe that they are inherently flawed in some way. Even the name “personality disorder” suggests an innate dysfunction occurring at a person’s core.

Of course, this is not the case – people who struggle with regulating their emotions have valid reasons for that struggle. This is part of what drew me to Dialectical Behavior Therapy (DBT), and part of why I joined Burrell’s comprehensive team as an intern a little over two years ago. DBT frames behavior nonjudgmentally, and at the same time, it makes clients responsible for improving their lives.

Burrell’s Southwest (SW) region team has been in place for years. As a fidelity DBT program, we offer weekly individual therapy sessions, weekly two-hour DBT skills groups, as well as coaching calls that clients can make to their individual therapists at any time. Team members are gracious with their time and have described exceptionally skillful ways of navigating sessions and coaching calls to increase clients’ agency over their lives. We also meet for two hours once weekly to staff cases, consult, learn from each other, and provide and receive support. It is genuinely the highlight of my week, each week, to meet with the team.

Burrell has recently expanded to add a Comprehensive team in the Central region as well, led by Stacy Parmer, LPC, LMFT. Stacy immediately took

on the leadership role with knowledge, grace, and confidence that I admire deeply. She was our point person for the fidelity review in August, and her team has grown tremendously since its start last year.

Burrell also has a residentially-based adolescent DBT program in Nixa led by Mitra Pedram, LCSW, which began in 2022. Burrell Behavioral Health’s Youth Residential program, Milano House, is a residential DBT program for youth between the ages of 13 and 17.9 who qualify for a residential level of care. The youth engage in at least 1 individual DBT therapy session every week, 1-2 group DBT sessions per week, and 1 family therapy DBT session each week. The individual and family therapists at Milano also teach DBT to all the staff who work within the program, so that transferrable skills can be taught and modeled throughout the environment. The DBT curriculum has been adapted to fit within the average length of stay of six months. One successful component of this program is that the youth become DBT experts and further their knowledge and skill by teaching DBT to one another, their families, and sometimes staff. There is rarely a youth who needs a residential level of care who doesn’t also need support in learning to be more skilled in the DBT module areas: distress tolerance, mindfulness, emotional regulation, and interpersonal effectiveness. We are proud to provide a safe environment for youth to heal from and work through trauma as well as learn the skills they need to have a life worth living.

The commitment DBT therapists in our programs make is significant, and it allows us the privilege of seeing tremendous growth, determination, and skill development in our clients.

Training reminders:

Team Leader Consortium—Oct 23’ through April 24’

Registration:

[Register HERE Today](#)

ITCD Webinar Series with David Lynde—Feb 8, 14 and 20th

This training is full!!

Missouri

Evidence Based Services
Newsletter

Fall 2023

For resource information on Supported Employment and Education services for Transitional Age Youth, visit the DMH website:

<https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/employment-services>

And click on
"Youth"

Harvard for Developing Child

<https://developingchild.harvard.edu/>

The National Child Traumatic Stress Network

<https://www.nctsn.org/>

ITCD Toolkit from SAMHSA

[Click Here](#)

Fidelity Corner

ITCD Ancillary Services *Part of the ITCD team or not?*

ITCD clients are most often involved in "ancillary" services within the agency. There is a specific scale item in the SAMHSA Protocol regarding ancillary services. It is ITCD protocol Item #4, Access to Comprehensive Services. This item assesses whether *the agency* offers additional supports in residential, supported employment, family interventions, Illness Management and Recovery (IMR) and Assertive Community Treatment (ACT). If the agency offers each of these services and at least one client within the agency (whether admitted to ITCD or not) is participating, then the service is counted as available to the clients in ITCD scale item #4. Each of those services are evidence based practices. SAMHSA offers a toolkit for that is similar to the co-occurring disorders kit that Missouri ITCD programming is based upon.

On the other hand, a "Multidisciplinary ITCD Team" includes a team leader (QMHP), co-occurring specialist (QAP), RN and physician or prescriber. These positions are required for the program per the DMH ITCD regulations (CSRs). The team may also elect to include additional staff representing ancillary services to their "ITCD team". If they do so, and those staff are formally considered part of the ITCD multidisciplinary team, then it is expected they would receive the same required co-occurring training as is expected in the GOI protocol for co-occurring treatment, would attend all ITCD multidisciplinary team meetings and would be serving identified ITCD clients in their role. This could include case managers, peers, housing staff, vocational specialists, outreach staff, etc.

In review of documentation such as progress notes and supplemental assessments during fidelity monitoring, it is expected that these would be primarily written by members included in the treatment team. This is especially important if the team is hoping to receive credit for evidence of interventions provided within ITCD principles of treatment such as use of Motivational Interviewing (MI), Stages of Change, Family Psy-

choeducation or counseling, Substance Use Counseling, Outreach, or Interventions to Promote Health per the protocol. This is because those staff applying these principles in treatment are assumed to be trained appropriately in co-occurring treatment provision which includes training in these principles specifically.

Other services provided such as residential, vocational, IMR, ACT and additional family interventions would be expected to be provided by the other service providers within the agency (ancillary service providers) who are not always part of the ITCD team. In other words they are not required to have received the co-occurring training per the GOI protocol. One example is a client receiving IMR or E-IMR from a PSR program which is an ancillary program available to ITCD clients. PSR staff may not have the required co-occurring training nor be attending ITCD multidisciplinary staffing (which is not required but is a best practice option.) IMR is not a key principle element of ITCD services. It is a nice ancillary treatment option that blends well with ITCD services. However, MI, stage based treatment and stages of change are key principles of ITCD treatment.

A problematic issue in fidelity is when co-occurring treatment program interventions are assumed to be provided by someone "outside" of the ITCD team, (case managers, peers, outreach teams, counselors) who have not had adequate training in the ITCD program principles and the team is hoping to get credit for evidence that those principles are used within their fidelity measures. If these ancillary staff are trained in ITCD (per the GOI protocol definition) then they should already be counted as part of the team. If they are not then it is recommended that they receive the training. Sometimes the interventions provided by untrained staff is not high quality nor do they apply the principles of co-occurring treatment. It is often case-management, med checks or engagement only. This naturally results in lower fidelity to the model for that program.



Online Manuals:

<http://navigateconsultants.org/manuals/>

Find out more about the TMACT Protocol here:

<http://www.institutebestpractices.org/tmact-fidelity/more-about-the-tmact/>

At the *Institute for Best Practices*

Have questions about WRAP trainings?

Contact

lori.franklin@dmh.mo.gov

Be sure to check out our training library links on these web pages under "Training Library" Click one below:

[ACT](#)

[ITCD](#)

[DBT](#)



RESOURCES



Center for Evidence-Based Practices at Case Western Reserve University

<http://www.centerforebp.case.edu/>

Individual Resiliency Training (IRT)

<http://navigateconsultants.org/manuals/>

Copeland Center for Wellness and Recovery

<http://copelandcenter.com/wellness-recovery-action-plan-wrap>

Division of Behavioral Health Employment Services

<https://dmh.mo.gov/mental-illness/employment-services>

IPS Employment Center

<https://ipsworks.org/>

Certified Peer Specialist

<https://dmh.mo.gov/mental-illness/peer-support-services>

SSI/SSDI Outreach, Access and Recovery (SOAR)

<http://soarworks.prainc.com/>

Missouri Department of Mental Health

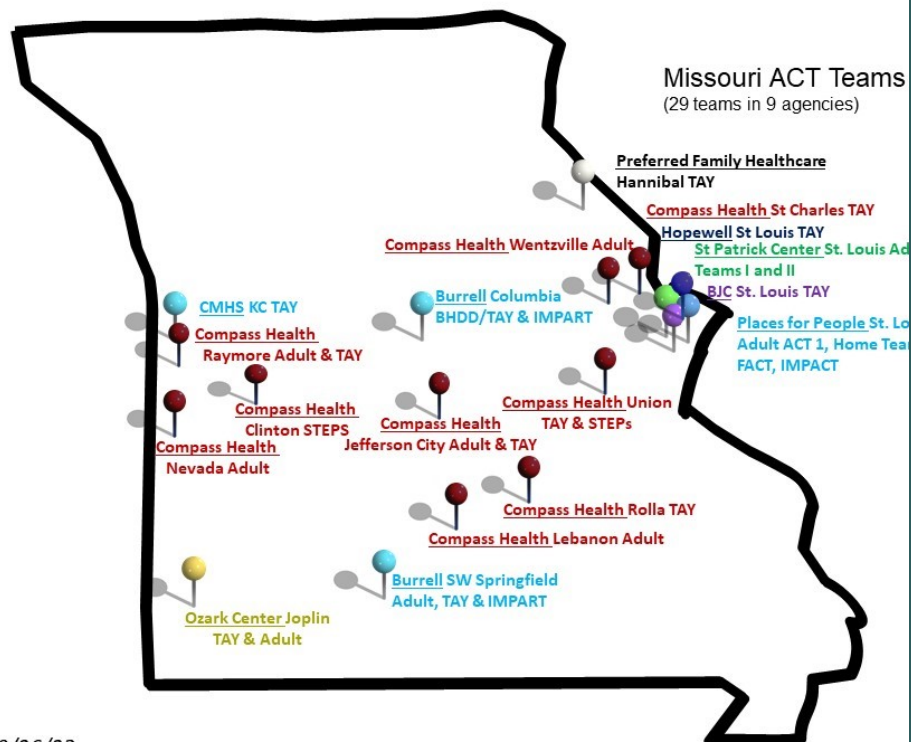
<https://dmh.mo.gov/behavioral-health>

Missouri Children Trauma Network

<https://www.mocn.com/>

Healthy Families of America

<https://www.healthyfamiliesamerica.org/>



Missouri
Evidence Based
Services Newsletter
Fall 2023



To access the free and downloadable **Supported Housing Toolkit** on the Substance Abuse and Mental Health Services Administration (SAMHSA) website:

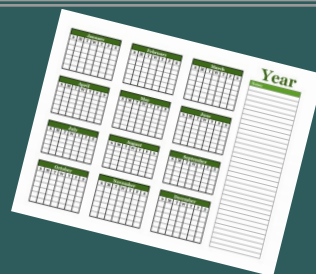
[CLICK HERE](#)



Take the free
SOAR
online
training
course by
visiting

<http://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training>

Save the Date!



Hey DBT Teams!

New learning opportunities are coming your way! The Missouri Behavioral Health Council and The Department of Mental Health are excited to bring DBT Teams more training and learning opportunities this year! These include DBT Learning Collaboratives and Lunch & Learns to enhance knowledge and refresh skills.

Mark your calendars now on these dates to attend:

November 9th - 12pm to 1pm Link: <https://event.me/bZ4xOM>

December -14th TBA 10am-3pm (Collaborative) Link Pending

January 11 -12pm to 1pm Link pending

February 8th TBA 10am-3pm (Collaborative) Link pending

March 14th -12pm to 1pm Link pending

DMH Fidelity Team

Lori Long, Coordinator
Lori.Long@dmh.mo.gov
417-448-9982
All regions

Fidelity Specialists:

Erin Hahs
Erin.Hahs@dmh.mo.gov
573-218-6972
Central Region

Milly Hall
Milly.Hall@dmh.mo.gov
417-448-3469
Western Region

Charie Sands
Charie.Sands@dmh.mo.gov
417-448-3456
Western Region

Bobbi Good
Bobbi.Good@dmh.mo.gov
816-387-2894
Western Region

Heather Senevey
Heather.Senevey@dmh.mo.gov
573-751-0436
Central Region

Sara Bellew
Sara.Bellew@dmh.mo.gov
573-218-5010
Central Region

Tom Geeding
Tom.Geeding@dmh.mo.gov
417-448-1192
Western Region

Missouri

Evidence Based Services
Newsletter

Fall 2023

NAMI Support
Group listings can
be found at:

[https://namimissouri.org/
support-groups/](https://namimissouri.org/support-groups/)



DBT website—information,
membership, training events,
certification, directory,
resources, links and support!

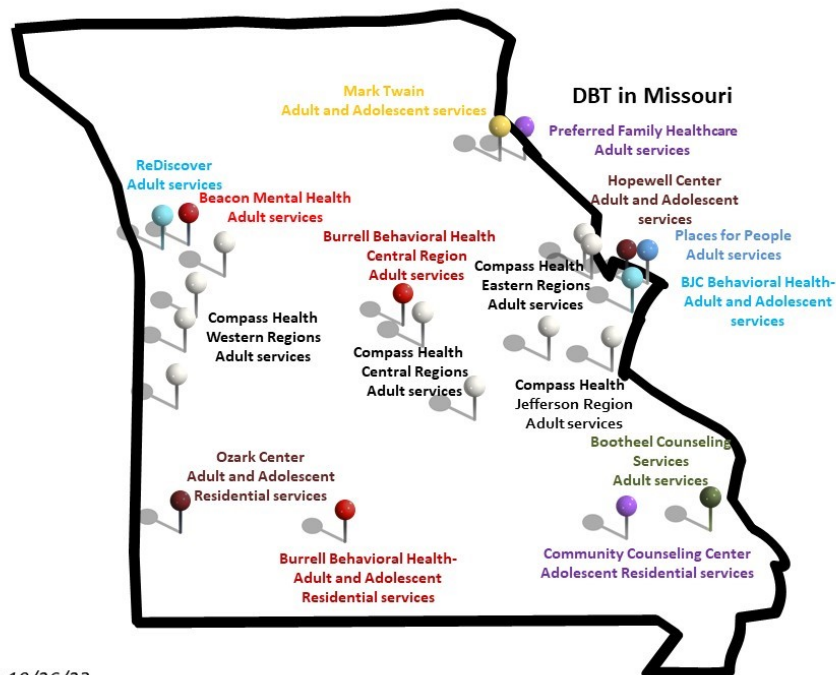
[Click Here](#)



Supporting Excellence in Behavioral Health
60 YEARS

National Association of State
Mental Health Program
Directors

[Click Here](#)

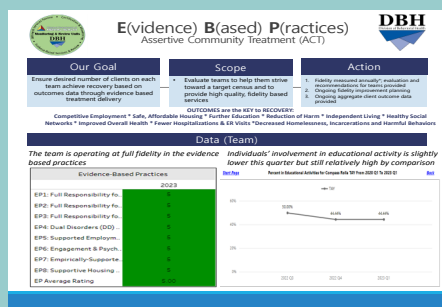


Rev 10/26/23

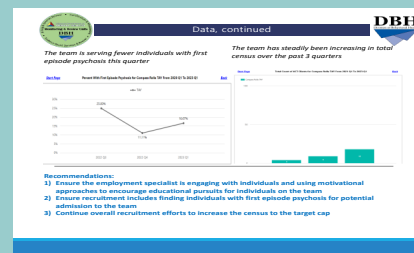
Evidence Based Practice Team Data Boards

As information gathering and data collection have become a key part of successful feedback toward high quality services, DMH is now including individualized team data within final fidelity reports. The purpose is to highlight key areas of

We will be including graphs and charts similar to the examples included here, containing scoring information, client outcome trends as well as some process data reporting. We hope that front line staff, program managers and CEOs alike will find the data easy to understand, useful and of interest. The data can help in demonstrating the importance of these



performance by the team or client outcome data from individuals served. In addition, we hope to spark further interest in requests for more data that may be useful to the programs and teams for future planning around process, outcome and performance data collection as well as for analysis of data in making identified changes within the program as indicated.



programs to their communities as well as key performance indicators and trends affecting the clients being served.

Please feel free to reach out to DMH if you have questions about data collected in your program and how it may be used in a helpful way within your EBP.

Missouri

Evidence Based Services

Newsletter

Fall 2023

If you have any questions about further developing Motivational Interviewing in your practice, feel free to contact Scott Kerby. He has information on free and cost effective products and can help with your Motivational Interviewing needs.

skerbyconsulting@gmail.com



**Rolla TAY
Team chefs at
Halloween!**

Motivational Interviewing Corner

By *Scott Kerby*

Supporting Persistence

There was a time that Motivational Interviewing was viewed as “completed” once a person made a commitment to a change direction. The thought was that MI was a valuable tool that was working to prepare people for change, build internal motivation, and then MI would hand off to a new strategy once the decision was made to pursue that change. Yet, over the years, many helpers using MI found that it did not work this way. Sure, often times people needed very little help once they decided to make a change, but for other clients the decision to change was just the beginning. For the latter group, their changes require sustained attention and effort over time. In the recently released 4th edition of *Motivational Interviewing* there is an emphasis on “Supporting Persistence” that looks at how MI can be utilized over a longer period of time with clients.

Many changes, like quitting smoking, often are quite the process. As Bill Miller writes, “Being a nonsmoker is different than thinking of oneself as a smoker on a temporary leave.” In this example, it often is a significant lifestyle change full of unanticipated consequences and new problems that arise. Miller lists four tasks that can help support persistence. The first is Re-Planning. We do this when there is an issue with the plan, or something needs adjusted. We might ask questions like “What next?”, “What now?”, or “What else” as we consider what other approaches might be tried instead. The second task is Re-Evoking. Sometimes people are struggling with a loss or wavering of commitment to their goal. Even with a good plan people often have doubts or feel less sure. They may be experiencing a slip in their confidence, which can undermine importance. The purpose of re-evoking is to review and renew the person’s reasons and intention to pursue the identified goal. Is this still the direction you want to move? If so, revisiting the client’s change talk can be very helpful. The third task is Re-Focusing. It is common for goals to shift, or progress actually revealing a bigger concern or problem that was unknown or seemed smaller at the outset. When it is the goal itself that needs adjusted, and not just renewing commitment, the needed task to refocus. This requires an open and direct discussion to collaboratively decide to change the heading together. Finally, the fourth task is Re-Engaging. If a client starts to miss appointments, or your “gauges” are going off, suggesting the client is not as engaged in the process, it could be a good time to revisit engagement. Ask for the client’s advice as to how you could be more helpful or supportive of their change process. Take time to really focus on the relationship and clearing up any confusion, hurt, or frustration. Without engagement it is almost impossible to make progress with the other tasks within MI.

Motivational Interviewing can be a wonderful short-term treatment that helps clients decide to change, and decide they really do not need us anymore. It can also be a long-term process of helping clients over time, supporting their persistence when change does not come easily or quickly.

Best of luck in your efforts to help people with change.

Until next time, keep reflecting.



Arts & Literature

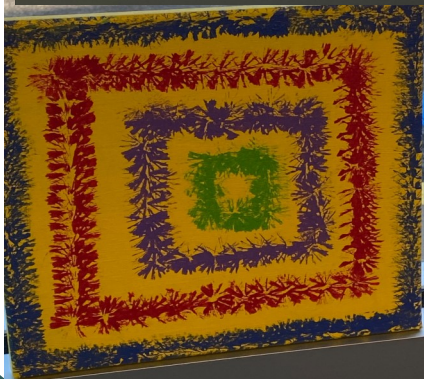
Expression



Creativity

Send art (photos, photos of artwork, testimonials, poems, etc.) to Lori Long at lori.long@dmh.mo.gov for submission to this newsletter.

Please indicate if the artist wishes to be named along with the location/ team they receive services from.
Thank you!



By Jean at
Compass
St. Peters

